

VOPA INVESTIGATION REPORT

**A CONSOLIDATED INVESTIGATION OF ABUSE OR NEGLECT OF
R.L. AND D.S. AT SOUTHEASTERN VIRGINIA TRAINING CENTER**

**VOPA CASE # 01-0063 AND # 01-0064
VIRGINIA OFFICE FOR PROTECTION AND ADVOCACY**

I. INTRODUCTION

The Virginia Office for Protection and Advocacy (VOPA) has investigated allegations of abuse and neglect involving two residents of Southeastern Virginia Training Center (SEVTC) in Chesapeake, Virginia. The residents are referred to herein as “R.L.” and “D.S.”¹

The investigation was conducted pursuant to Title 42 *United States Code* §15000, et seq., the Developmental Disabilities Assistance and Bill of Rights Act, Title 42 *Code of Federal Regulations* §1386.19 et seq., and §51.5-39.4, *Code of Virginia* (1950 as amended).² This report is issued pursuant to §51.5-39.8.C.1., *Code of Virginia* (1950 as amended).

The investigation was initiated pursuant to the VOPA Director’s certification of probable cause to believe that abuse or neglect occurred based on review and analysis of reports provided by SEVTC that indicated that, on or about January 1, 2001, R.L. was shot with a BB gun and D.S. sustained a laceration to his left palm. The injury reports were provided to VOPA on January 3, 2001 pursuant to §51.5-39.12, *Code of Virginia* (1950 as amended)³, and stated that the residents’ injuries were discovered by SEVTC staff on January 2, 2001.

While the investigation was ongoing, VOPA discovered that, shortly prior to the alleged shooting, R.L. sustained serious bruises on his upper arms. These injuries were discovered by SEVTC staff on or about December 18, 2000 but were not reported to R.L.’s Authorized Representative (AR) or to VOPA. Also, while the initial investigation was ongoing, VOPA discovered that D.S. did not have an authorized representative or legal guardian. On February 21, 2001, SEVTC provided a report of alleged sexual abuse involving R.L. The initial VOPA investigation was expanded to address these additional injuries, allegations, and issues.

On December 17, 2002, VOPA forwarded a draft of this report to the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) Commissioner James S. Reinhard, M.D., for comment. On January 24, 2003, Dr. Reinhard responded, whose response is posted along with this report.

II. SUMMARY OF FACTS

R.L. and D.S. are adult residents of Southeastern Virginia Training Center. They reside in a cottage with eight other residents. In December 2000, R.L. was assaulted and battered by an SEVTC staff person, resulting in severe bruising. He was sent to a nurse. Neither cottage staff nor the nurse notified the Facility Director of the assault and battery pursuant to applicable Departmental Instructions of the Department of Mental Health, Mental Retardation and

¹ In Virginia, the designated protection and advocacy (P&A) system is the Virginia Office for Protection and Advocacy (VOPA). This designation was effective on July 16, 2002. Prior to that time, the designated P&A system was the Department for Rights of Virginians with Disabilities (DRVD). The terms “VOPA” or “the office” are used in this report to refer to VOPA or its predecessor, DRVD.

² Formerly §51.5-37, *Code of Virginia* (1950 as amended).

³ Formerly §51.5-37.2.C.1., *Code of Virginia* (1950 as amended).

Substance Abuse Services, and R.L.'s Authorized Representative was not notified as required by SEVTC Guidelines. Several days after the assault, the Authorized Representative discovered the bruises and contacted cottage staff who then reported the incident to the Facility Director. An internal investigation was initiated but concluded that abuse could not be substantiated. SEVTC did not report the assault and battery to VOPA.

In January 2001, R.L. and D.S. were shot with a pellet gun by the staff person who committed the assault and battery. R.L.'s AR and VOPA were notified of the incident. D.S. did not have an AR as required by applicable regulations. An internal investigation by DMHMRSAS was initiated and resulted in a finding of abuse. The staff person and a second employee who was present at the time of the shooting were fired. Approximately three months after the shootings, R.L. alleged that he was also sexually abused by the employee who shot him. An internal investigation of this allegation was conducted by DMHMRSAS and resulted in a finding that the alleged sexual abuse could not be substantiated. In July 2001, R.L.'s AR asked that the internal investigation findings on the assault and battery and sexual abuse allegations be appealed to the Local Human Rights Committee for review, as provided for in DMHMRSAS Departmental Instruction 201 (DI 201). The AR submitted a written request for review of the internal investigation findings in December 2001. In spite of these requests, the findings were not presented to the Local Human Rights Committee until October 3, 2002, resulting in a decision on October 11, 2002, finding that both the assault and battery and the sexual assault occurred as reported by R.L., but that there was "no conclusive evidence as to who perpetrated the events."

Prior to hiring the person who shot R.L. and D.S. and the employee who was present at the time of the shootings, SEVTC did not obtain a national criminal records report concerning the gunman's criminal history as required by state law, did not follow state policy requiring reference checks, and did not make adequate inquiry concerning the second employee's written statement that he had previously been convicted of assault and battery.

III. SUMMARY OF FINDINGS

- A. R.L. was subjected to "abuse" by an SEVTC employee when he was grabbed and/or struck in a manner that inflicted serious bruising.
- B. SEVTC staff failed to immediately report R.L.'s bruises to the Facility Director and R.L.'s Authorized Representative when the bruises were discovered, as required by DMHMRSAS DI 201 and SEVTC Guidelines.
- C. In spite of the severity of R.L.'s bruises, SEVTC did not notify VOPA of the bruises even though an internal SEVTC investigation was initiated.
- D. R.L. was subjected to "abuse" by an SEVTC employee when he was shot with a pellet gun.
- E. D.S. was subjected to "abuse" by an SEVTC employee when he was shot with a pellet gun.

- F. Had SEVTC notified VOPA of R.L.'s serious bruises, it is possible that heightened scrutiny and a competent investigation might have prevented the subsequent shootings of R.L. and D.S.
- G. SEVTC's Facility Director failed to designate an AR for D.S.
- H. DMHMRSAS failed to promptly present the AR's appeal of the bruising and sexual abuse investigative findings to the Local Human Rights Committee.
- I. SEVTC failed to implement statutory and policy requirements related to pre-employment screening of the employee who committed the shooting. Specifically:
 - 1. SEVTC failed to obtain a national criminal records check as required by *Virginia Code* §37.1-20.3 and DMHMRSAS Departmental Instruction 78.
 - 2. SEVTC failed to conduct adequate reference checks and otherwise check prior employment records as required by Policy 2.10 of the Department of Human Resource Management, Policies and Procedures Manual.
- J. SEVTC failed to require the second employee to properly and adequately complete the required disclosure of prior criminal convictions, and failed to make adequate follow-up inquiry concerning the employee's statement that he was convicted of a crime.

IV. METHODOLOGY OF INVESTIGATION

The following documents pertaining to R.L. were obtained and reviewed:

- A. Daily care and treatment notes;
- B. Neurobehavioral records, reports, and notes;
- C. Doctor's orders and medical records;
- D. Psychological evaluations;
- E. Incident reports;
- F. Internal investigation report pertaining to the shooting;
- G. Internal investigation report pertaining to severe bruising of the arms;
- H. Internal investigation report concerning allegations of sexual abuse;
- I. SEVTC Programming Guideline No. 25, "Guidelines for the Involvement of Parents or Guardians In Residential Programming;"

- J. DMHMRSAS Departmental Instruction 201 (RTS) 00 “Reporting and Investigating Abuse and Neglect of Clients;”
- K. DMHMRSAS Departmental Instruction 401 (RM) 99 “Risk Management Program;”
- L. DMHMRSAS Departmental Instruction 506 (HRM) 98 “Candidate, Employee, and Unpaid Service Provider Background Verification and Notification Requirements;”
- M. Department of Human Resource Management, Policies and Procedures Manual, No. 2.10;
- N. Photographs of R.L. dated December 27, 2000 showing extensive bruising on the arms;
- O. SEVTC employee background checks, personal disclosure statements, and Employment Verification form;
- P. Personal Disclosure Statement;
- Q. Employment Applications;
- R. Review of Employee Time Cards for employees who worked at Cottage 1A from the period December 25, 2000 through January 9, 2001;
- S. Letter from J. K. to M. L. dated June 7, 2000;
- T. Letter from J. K. to W. M. dated June 29, 2000; and
- U. Letter from SEVTC dated February 20, 2002.

The following documents pertaining to D.S. were obtained and reviewed:

- A. Daily care and treatment notes;
- B. Neurobehavioral records, reports and notes;
- C. Doctor’s orders and medical records;
- D. Psychological evaluations;
- E. Incident reports;
- F. Court orders pertaining to the treatment;
- G. Policies as listed above; and

H. Hospital records of D.S. from Chesapeake General Hospital dated January 2, 2001.

The following interviews were conducted:

- A. Interviews of shooting victim R.L.;
- B. Observation of and attempted communication with shooting victim D.S.;
- C. Cottage resident B.C.;
- D. Cottage Team Leader;
- E. Assistant Program Manager;
- F. Cottage staff, nurse, and doctor;
- G. SEVTC Director;
- H. Family member;
- I. Assistant Commonwealth's Attorneys and Detectives;
- J. SEVTC Risk Manager and former Internal Investigator;
- K. SEVTC Internal Investigator;
- L. DMHMRSAS Internal Advocate;
- M. Human Resources Directors of prior employers of the SEVTC staff person who shot R.L. and D.S.; and
- N. State Human Resource Analyst.

V. BACKGROUND

A. The Facility

Southeastern Virginia Training Center is a training and long-term care facility for persons with mental retardation located in Chesapeake, Virginia. SEVTC has approximately 200 residents who reside in cottages with staff support.

R.L. and D.S. reside with eight other persons in a cottage designated for residents who, according to the Facility, exhibit difficult behaviors. The cottage doors are locked at all times. No other SEVTC cottage maintains locked doors at all times. The stated goal for R.L., D.S., and the other cottage residents is discharge to the community.

B. Resident R.L.

R.L. is a twenty-seven year old Caucasian male with mild mental retardation, bipolar disorder, and an Axis I diagnosis of Intermittent Explosive Disorder. R.L. has good receptive and expressive skills, can verbally express his needs, and is able to follow verbal and simple written instructions. R.L. can read and write words at about the fourth grade level, has an excellent memory for names and dates, including his birthday, and can recall the names of staff and other residents.

C. Resident D.S.

D.S. is a thirty-eight year old African-American male with severe mental retardation and bipolar disorder. At age ten, he was placed at Central State Hospital (CSH) but was transferred to an out-of-state residential program because CSH was unable to meet his needs. At age thirteen, he was placed at SEVTC, where he has remained for twenty-five years. D.S. is ambulatory, speaks by using short phrases and simple sentences, dresses himself, and is able to eat and bathe without assistance. He exhibits impaired socialization and adaptive skills, is occasionally aggressive, and requires supervision outside of the cottage.

VI. FACTS

A. R.L.'s Bruises Prior to the Shooting

R.L.'s mother (hereinafter Mrs. S) states that, on or about November 2000, R.L. appeared upset and frightened. She didn't know why. On December 24, 2000, she discovered severe bruises on his upper arms. When asked, R.L. told her that a staff member pushed him against a washer and dryer and hit him with a shoe. He provided the name of a staff member. On December 26, 2000, she asked her sister to photograph the bruises and Mrs. S. reported both the bruises as well as R.L.'s statement to the cottage staff. However, Mrs. S. found that the staff was already aware of the bruises and that R.L. had previously been seen by a nurse for the bruises.

A Critical Incident Report setting forth the facts pertaining to the bruising was not completed and forwarded to the Director of VOPA within forty-eight hours of the incident. Likewise, a written report setting forth the known facts pertaining to the bruising was not completed by the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services and forwarded to the Director of VOPA within fifteen working days of the date of the incident.

SEVTC records indicate that Mrs. S. serves as R.L.'s Authorized Representative. She was not notified by the cottage staff or nurse when the bruises were first discovered, nor did the cottage staff or nurse notify the Facility Director at the time of discovery. After Mrs. S.'s report to the cottage staff, the bruises were reported to the Facility Director. An internal investigation was initiated, but the investigation concluded that the staff member initially identified by R.L. did not inflict the bruises and the alleged abuse could not be substantiated.

During the internal investigation, the investigator, who at the time also served as the Facility's Risk Manager, concluded that the bruises were likely inflicted on or about December 18, 2000. The investigator reviewed the cottage shift log and patient records, interviewed R.L., who provided inconsistent statements, interviewed Mrs. S. by telephone, and interviewed the alleged perpetrator. However, the internal investigation report does not indicate that the investigator reviewed the photographs, which show significant bruising, and the investigator did not interview the nurse or other medical staff. Additionally, there was no follow up from the investigator or DMHMRSAS when, after the shooting, R.L. stated that the person who inflicted the bruises was the person who shot him. Notwithstanding this new information, the internal investigation remained closed and the finding that abuse and neglect could not be substantiated was not further addressed.⁴ All internal investigations are reviewed at two higher levels within DMHMRSAS.

B. The Shootings

On January 1, 2001, R.L. and D.S. were shot with a BB gun by a staff member who worked in the cottage. The gun was capable of firing either BB's or pellets. R.L. was shot in the back with a pellet. D.S. was shot in the hand with a pellet. The gunman was identified and charged by law enforcement authorities with unlawful discharge of a firearm in violation of *Virginia Code* §18.2-279 and two counts of assault and battery in violation of *Virginia Code* §18.2-57. Another staff person was in the cottage at the time of the shootings but was not charged. When the police came to the cottage, the floor was littered with pellets.

On the day of the shooting, the employee who did the shooting reported to work carrying a gym bag that he said contained books. Two other employees were in the cottage at the time. Neither was a supervisor and the bag was not searched. Before the shootings, the employee removed the gun from the bag and showed it to the co-worker who was in the cottage at the time of the shootings. The third employee did not see the gun. Later, the third employee escorted several of the residents out of the cottage for recreation. R.L. remained in the cottage by preference and D.S. remained because he required close supervision to assure that he didn't leave the area. The person who did the shooting and the second employee remained in the cottage with R.L. and D.S. The shootings occurred while the third employee and the other residents were out of the cottage. When the third employee and the other residents returned to the cottage, R.L. and D.S. were in their rooms. The third employee noticed no signs or indication that R.L. and D.S. had been shot.

Each of the three staff members working in the cottage on the day of the shooting, including the gunman, was designated, for employment purposes, as Developmental Disabilities Specialist 1. Each had been employed in this capacity for less than one year. No supervisor was in the cottage at the time of or directly before the shooting.

⁴ In correspondence dated June 14, 2002, DMHMRSAS states that the bruising investigation was reassigned from the initial investigator to a second investigator. The internal investigation report provided by SEVTC does not reflect this reassignment.

Later on January 1, 2001, D.S. complained to another staff member that he hurt his hand with a fork. D.S. was not sent to the nurse at the time. The staff member that received the complaint was later terminated for failure to refer D.S.'s complaint to a nurse as required by SEVTC policy.

On the following day, January 2, 2001, R.L. approached yet another staff member and stated that a staff person shot him with a "pellet" gun. R.L. identified the gunman. R.L. was examined and a small red bruise was found on his back. R.L. was referred to a nurse, along with D.S. and the other cottage residents. The nurse examined R.L.'s back, washed it, and applied antibiotic cream. She then called the SEVTC physician to report the injury, as well as the Risk Manager. D.S. was taken to a hospital for x-rays, which were negative. D.S.'s wound was treated and he was returned to SEVTC. On January 3, 2001, R.L. and D.S. were examined by an SEVTC physician who found that R.L. had a six millimeter abrasion on his mid back that did not require further treatment. D.S.'s hand was treated with an antibiotic cream, and noted that it looked as if a pellet had penetrated the skin. The physician stated that neither victim was permanently injured.

An internal investigation was initiated on January 2, 2001. On January 3, 2001, the SEVTC Facility Director notified Mrs. S., described the incident and, according to Mrs. S., stated that R.L. "was fine." VOPA was notified on the same date pursuant to *Virginia Code* §51.5-37.1.⁵ The internal investigation proceeded, during which the "second employee" admitted that he saw the BB gun but failed to report it.

On January 2, 2001, SEVTC reported the incident to the Virginia State Police. The State Police forwarded the investigation to the Chesapeake Police Department and a criminal investigation was initiated. Physical evidence was recovered from the cottage and the gunman was arrested and charged with unlawful discharge of a firearm in violation of *Virginia Code* §18.2-279 and two counts of assault and battery in violation of *Virginia Code* §18.2-57. The second employee was not charged.

C. Subsequent Allegations of Sexual Abuse

On February 19, 2001, R.L. told his mother that he had been sexually abused by the person who shot him. The following day, R.L. reported the alleged sexual abuse to cottage staff, stating that the gunman inserted his finger in his rectum when he was in the shower. The allegation was reported to the Facility Director who immediately notified the police. A critical incident report was forwarded to VOPA pursuant to *Virginia Code* §51.5-37.1.⁶

An internal investigation was initiated but, due to the pending law enforcement investigation, the internal investigation was "suspended." At the same time a conclusion was drawn in the internal investigation report which states that "abuse cannot be substantiated at this time. Therefore, this investigation is complete pending the discovery of any additional information."

⁵ Now §51.5-39.12, *Code of Virginia* (1950 as amended).

⁶ Now §51.5-39.12, *Code of Virginia* (1950 as amended).

The law enforcement investigation concluded that there was insufficient evidence to prosecute.

D. AR's Appeal of the Internal Investigation Findings

DMHMRSAS Departmental Instruction 201 allows an Authorized Representative to appeal the internal investigation findings to the Local Human Rights Committee (LHRC) if the AR is dissatisfied with such findings. R.L.'s AR, both orally and in writing, notified SEVTC staff of her desire that the LHRC review the investigative findings concerning R.L.'s bruises and the sexual abuse allegations. The AR's request for review states as follows:

This letter is to confirm that I want to appeal two SEVTC internal investigation reports to the Local Human Rights Committee. I wish to appeal the investigation report in which the allegation that [R.L.] was abused because his body was covered in bruises. I do not believe that the investigation was conducted properly and I want it appealed on this basis. The investigator did not do his job properly. Hardly anyone was interviewed for the investigation. The investigator should have gone around in the cottage and interviewed the staff to see what was going on. Also, I had pictures of [R.L.'s] bruises and the investigator didn't even look at the pictures. The pictures made it look as if someone had grabbed [R.L.] by the arms. [R.L.'s] medical records were not reviewed. If the investigator had done a more thorough job, perhaps the pellet gun shooting, which came later never would have happened.

I also wish to appeal the investigation report pertaining to the allegation of sexual abuse in which [R.L.] said that he had been penetrated anally by [the gunman]. Again, it is my opinion that the investigator did a poor job. In both of these investigations, the investigator concluded the report by saying that the claims were unfounded. Therefore, the excuse that the investigator did not do more work because the police got involved in the cases is unacceptable because the investigator made a determination based on the minimal amount of work that he did. If the investigations became a police matter and the investigations were halted, then there should not have been conclusions made by the investigator that there was no abuse or not enough evidence. I want these reports brought to the attention of the Local Human Rights Committee so that they can see the poor quality of internal investigations that are going on at Southeastern Virginia Training Center. These investigations are a joke. I want them to see what's going on so that they can make sure that the investigator gets training if that's what needs to happen or that an investigator who does the job is assigned to investigate the internal abuse cases. Please forward a copy of this complaint to the Local Human Rights Committee.

The oral requests for LHRC review were made to a DMHMRSAS employee beginning in July 2001, and the written request for review was sent to the same employee in December 2001.⁷ Notwithstanding the AR's requests, the matter was not presented to the LHRC until October 2, 2002. On October 11, 2002, the LHRC concluded that the assault resulting in bruising and the sexual assault occurred as reported by R.L. but that there was insufficient evidence to conclude who committed each instance of abuse. The LHRC further concluded that the internal investigations of the incidents were conducted properly under the regulations in effect at the time, but that investigative procedures have changed and that investigators' training "is now more comprehensive."

E. VOPA's Witness and Victim Interviews

R.L. credibly and coherently confirmed the gunman's actions to VOPA, stating that he was mad; that he shot him (R.L.) on the arms and back when he was in the shower; that the shooting occurred on New Year's Day; that he was afraid; that the gunman shot two other residents; and sprayed two other residents with a water bottle. He described the second employee as "mean."

D.S. had greater difficulty discussing the shootings with VOPA, due in part to his lack of verbal skills and apparent trauma. When interviewed, he stated that he cut his hand with a knife. He then got up and ran from the interview room.

VOPA also interviewed resident B.C., who is observant and well spoken. B.C. stated that, in the past, the person who shot R.L. and D.S. hit him, B.C., in the face with a basketball, grabbed him by the neck and choked him when no one else was around, pushed him roughly down on the bed, was generally mean to other residents and hit them with rolled-up towels, which hurt. B.C. stated that the "second employee" pushed him and was rude.

VOPA has been unable to interview the second employee, who fled the state and continues to evade the police.

F. The Gunman and the Second Employee were Suspended, then Terminated

Pursuant to DMHMRSAS Departmental Instruction 201, the gunman and the second employee who saw the gun were suspended on January 5, 2001 pending a full investigation.

⁷ DMHMRSAS' current Human Rights Regulations, adopted November 21, 2001, state that "[i]f the individual affected by the alleged abuse, neglect or exploitation or his legally authorized representative is not satisfied with the director's actions, he or his legally authorized representative, or anyone acting on his behalf, may file a petition for an LHRC hearing under 12 VAC 35-115-180." See 12 *Virginia Administrative Code* §35-115-50 (regulations of the State Board of Mental Health, Mental Retardation and Substance Abuse Services). The AR's written request for LHRC review was submitted on December 13, 2001. Therefore, the AR had a right to LHRC review both under DI 201 and the Human Rights Regulations. However, DMHMRSAS failed to present the AR's request for LHRC review until fifteen months after the AR's oral request and ten months after the written request.

following an internal investigation and consultation with local police, SEVTC concluded that there was substantial evidence to indicate that abuse occurred. On January 11, 2001, pursuant to DI 201, which states that “[i]t is expected that a facility director will terminate an employee(s) found to have abused or neglected a client[.]” the gunman and the second employee were terminated.

G. Coordination with Law Enforcement Authorities

VOPA provided information obtained in its investigation to and fully cooperated with appropriate law enforcement authorities.⁸

H. The Gunman’s Criminal Trial

The gunman’s trial on three misdemeanor charges, including discharging a firearm in a public building and two counts of assault and battery, was initially scheduled for February 26, 2001. The prosecution dismissed the charge of discharging a firearm in a public building based on its conclusion that a BB gun is not a firearm covered by the applicable statute. Four SEVTC employees appeared to testify but trial of the remaining charges did not proceed because the second employee, who had been subpoenaed, failed to appear. The trial was continued to March 30, 2001.

On March 30, 2001, three SEVTC employees failed to appear for trial. The prosecution expressed surprise at this development. The second employee also failed to appear. A bench warrant was issued for his arrest. Based on the witnesses’ failure to appear at trial, the charges were voluntarily dismissed by the prosecution.

VOPA spoke to the SEVTC employees who failed to appear for trial. One stated that “he forgot.” Another stated that the subpoena arrived after March 30.

Law enforcement authorities are seeking the “second employee” and state that the charges may be reinstated if the “second employee” is found.

I. Pre-Employment Screening and Related Procedures

Applicants for employment at SEVTC must complete a state job application, provide references, list previous employers, reveal prior criminal convictions, and undergo a state and national criminal background check pursuant to *Virginia Code* §37.1-20.3, which section directs that DMHMRSAS “shall not hire for compensated employment persons who have been (i) convicted of . . . assault and bodily wounding as set out in Article 4 (§18.2-51 et seq.) of Chapter 4 of Title 18.2. . . .” State hiring policy 2.10 which is applicable for full- or part-time state employees requires that management personnel contact both the current and at least one former supervisor of a final applicant for a position. Such contact must be documented in the file.

⁸ VOPA’s investigation and publication of this report were delayed due to the ongoing criminal investigation and due to DMHMRSAS’ delay in presenting the AR’s request for LHRC review.

According to SEVTC, the gunman's personnel file includes documentation that a state criminal records check was performed but does not include documentation that an FBI criminal records check was performed. With regard to reference checks, the SEVTC record indicates that references were contacted by an SEVTC employee, but the employee is not identified and there is no indication which references were contacted.

Two of the gunman's prior employers were interviewed by VOPA. One states that it did not receive a written "reference or prior employment inquiry" from SEVTC and, while documentation of an oral inquiry is not kept, its response to an oral inquiry would be limited to verification of a period of employment. Had SEVTC made a written "reference or prior employment inquiry," the prior employer would have communicated the content of the gunman's employment record, including that the individual used poor judgment, could not make independent decisions, and voluntarily resigned. Another prior employer states that the gunman was terminated.

By correspondence to VOPA dated February 20, 2002, SEVTC stated that reference checks were not done for the second employee. The letter states:

there were no reference checks on [second employee]. He was a P14 and at that time the checks were done by the cottage supervisors and the references were not retained. The policy has now been changed.

SEVTC's employment application materials include the following: "Have you ever been convicted for any violations(s) of law or are you the subject of pending charges for any offense, including moving traffic violations inside and outside the Commonwealth of Virginia? If yes, please list and include: description of offense, statute or ordinance, date of charge, date of conviction and County, City, State of conviction." The second employee responded "yes" to the question and wrote "A&B Jan. 00." The remainder of the requested information (statute or ordinance, date of charge, date of conviction and County, City, State of conviction) was not provided.

VII. ANALYSIS AND FINDINGS

A. Abuse

Title 45 *Code of Federal Regulations* §1386.19 (Regulations of the United States Department of Health and Human Services, Administration on Developmental Disabilities) defines "abuse" as follows:

Abuse means any act or failure to act which was performed, or which was failed to be performed, knowingly, recklessly, or intentionally, and which caused, or may have caused, injury or death to an individual with developmental disabilities, and includes such acts as: verbal, nonverbal, mental and emotional harassment; rape or sexual assault; striking; the use of excessive force when placing such an individual in bodily restraints; the use of bodily or chemical restraints which is not in compliance with

Federal and State laws and regulations or any other practice which is likely to cause immediate physical or psychological harm or result in long term harm if such practices continue.

DI 201 defines “abuse” as follows:

Abuse means any act or failure to act by an employee or other person responsible for the care of an individual that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury, or death to a person receiving care or treatment for mental illness, mental retardation or substance abuse. Examples of abuse include, but are not limited to, acts such as:

- Rape, sexual assault, or other criminal sexual behavior;
- Assault or battery;
- Use of language that demeans, threatens, intimidates or humiliates the person;
- Misuse or misappropriation of the person's assets, goods or property;
- Use of excessive force when placing a person in physical or mechanical restraint;
- Use of physical or mechanical restraints on a person that is not in compliance with federal and state laws, regulations, and policies, professionally accepted standards of practice or the person's individualized services plan; and
- Use of more restrictive or intensive services or denial of services to punish the person or that is not consistent with his individualized services plan.⁹

Based on the facts set forth at pages 6 through 8, above, the gunman knowingly struck R.L. on or about December 18, 2000, resulting in R.L. being injured, and knowingly shot R.L. and D.S. with a pellet gun on or about January 1, 2001, resulting in their injury. With regard to the allegations of sexual abuse described at page 8, above, given the strong direct and corroborative evidence that the other incidents of abuse occurred in the manner specifically and credibly described by R.L., and the finding of the LHRC that the sexual abuse incident occurred as described by R.L., there is strong reason to believe that the allegations of sexual abuse are true.

Based on the foregoing, VPOA finds as follows:

1. R.L. was subjected to “abuse” by an SEVTC employee when, on or about December 18, 2000, he was grabbed and/or struck in a manner to inflict serious bruising.

⁹ The current Human Rights Regulations define “abuse” in virtually identical terms. Title 12 *Virginia Administrative Code* §35-115-30.

2. R.L. was subjected to “abuse” by an SEVTC employee when, on or about January 1, 2001, he was shot with a pellet gun.
3. D.S. was subjected to “abuse” by an SEVTC employee when, on or about January 1, 2001, he was shot with a pellet gun.

B. D.S.’s Right to Have an Authorized Representative

Former Title 12 *Virginia Administrative Code* §35-110-10, et seq. required appointment of an Authorized Representative for residents who were unable to make informed decisions.¹⁰

The current Human Rights Regulations (Title 12 *Virginia Administrative Code* §35-115-70) provide in pertinent part:

- A. Each individual has a right to participate meaningfully in decisions regarding all aspects of services affecting him. This includes the right to:

...

8. Have a legally authorized representative make decisions for him in cases where the individual lacks capacity to give informed consent.

...

- B. The provider’s duties:

...

9. When it is determined that an individual lacks the capacity to give consent, the provider shall designate a legally authorized representative. The director shall have the primary responsibility for determining the availability of and designating a legally authorized representative. . . .

D.S. is unable to participate meaningfully in decisions regarding his services and provide “informed consent.” Therefore, VOPA finds that the SEVTC Facility Director was required, and continues to be required, to designate an appropriate Authorized Representative to serve on D.S.’s behalf. At the time of the shootings and thereafter, this was not done, which

¹⁰ The former Human Rights Regulations allowed the Facility Director to serve as Authorized Representative when there was no legal guardian or qualified next-of-kin if approved by the Local Human Rights Committee (LHRC). Subsequent to adoption of the former regulations and prior to promulgation of the current Human Rights Regulations, §37.1-84.1, *Code of Virginia*, was enacted precluding Facility Directors and other DMHMRSAS employees from serving as a resident’s Authorized Representative.

violated and continues to violate D.S.'s rights under the DMHMRSAS Human Rights Regulations.

C. Violation of Statutory, Regulatory, and Other Reporting Requirements

DI 201 states in pertinent part:

...

Employees and other service provider(s), including volunteers must:

- Immediately report any incident or allegation that could constitute abuse or neglect to the facility director. . . .¹¹

SEVTC's "Guidelines for the Involvement of Parents or Guardians In Residential Programming" state as follows:

Guideline 8 (B):

...

- (1) Medical incidents – admission to the infirmary, serious illness, accidents, trips to the hospital.

Contacts regarding medical issues will be made by the Primary Nurse or another Center nurse. The cottage team leader will follow-up to ensure that authorized representatives are informed about significant medical events. The team leader and primary nurse will be guided by AR's preferences for information on issues of lesser significance; . . .

SEVTC's cottage staff discovered R.L.'s bruises on or about December 18, 2000 and, based on their assessment of the severity of the bruises, sought and obtained medical attention by the nurse. The bruises were "injuries" that might have been caused by "striking," and therefore might have resulted from abuse as defined at Title 42 *Code of Federal Regulations* §1386.19. Therefore, pursuant to DI 201, cottage staff and the nurse were required to immediately report the bruises to the Facility Director. This was not done. As a result, the Facility Director did not initiate an internal investigation as required by DI 201. Likewise, neither the cottage staff nor the nurse notified R.L.'s Authorized Representative of the bruises and examination by the nurse as required by SEVTC Guideline 8 (B).

In addition, the SEVTC Facility Director did not provide a Critical Incident Report to VOPA concerning the bruises.

¹¹ The current Human Rights Regulations likewise require DMHMRSAS employees to "immediately report" suspected abuse to the Facility Director. Title 12 *Virginia Administrative Code* §35-115-50.

*Virginia Code §51.5-39.12*¹² states:

Notwithstanding any other provision of law, the directors of state facilities as defined in §37.1-1 shall notify the Director of the [Virginia Office for Protection and Advocacy] in writing within forty-eight hours of critical incidents or deaths of patients or residents in state facilities. For purposes of this section, a critical incident shall be defined as serious bodily injury or loss of consciousness requiring medical treatment. The Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services shall provide to the Director of the Department a written report setting forth the known facts of critical incidents or deaths of patients or residents of facilities within fifteen working days of the critical incident or death.

In correspondence to VOPA dated June 19, 2002, the Facility Director stated that:

"A Critical Incident Report was not completed because the requirements of 51.5-37.1 were not met. That statute defines a critical incident as . . . "serious bodily injury or loss of consciousness requiring medical treatment..."

Following an assessment of [R.L.'s] bruises by the nurse on December 18, 2000, medical treatment was not required, therefore, no Critical Incident Report was required and no report made to your Department."

Addressing the above quoted correspondence, other DMHMRSAS facilities have completed and forwarded Critical Incident Reports to VOPA in cases involving bruising where the resident was seen by medical personnel but further "medical treatment" was not required. Indeed, a short time after R.L.'s bruising was discovered, SEVTC itself submitted a Critical Incident Report where a resident was bruised and seen by medical personnel, but treatment was not required. Nevertheless, assuming and hoping that no other factors affected or motivated the decision not to complete and forward a Critical Incident Report, including that more than 24 hours had passed since discovery of the bruises by cottage personnel, DMHMRSAS should carefully evaluate its current standards for critical incident reporting and enforce uniformity among facilities.

In the final analysis, however, reports clearly required by DI 201 and SEVTC Guidelines were not made, including a report to R.L.'s Authorized Representative, and the required internal investigation was not timely initiated. Had these steps been taken, heightened scrutiny by SEVTC supervisors and by R.L.'s Authorized Representative, followed by a competent investigation, might have affected subsequent events including, as observed by R.L.'s Authorized Representative, the shootings.

Based on the facts and the applicable Departmental Instruction and Guidelines, VOPA finds as follows:

¹² Formerly §51.5-37, *Code of Virginia* (1950 as amended).

1. SEVTC staff failed to immediately report R.L.'s bruises to the Facility Director, as required by DMHMRSAS Departmental Instruction 201 when such bruises were discovered on or about December 18, 2000.
2. SEVTC staff failed to report R.L.'s bruises to his Authorized Representative when such bruises were discovered on or about December 18, 2000, as required by SEVTC Guidelines.
3. The SEVTC Facility Director failed to report R.L.'s bruises to his Authorized Representative when such bruises were brought to the Facility Director's attention on or about December 24, 2000, as required by DMHMRSAS policy.
4. The SEVTC Facility Director failed to notify VOPA of R.L.'s bruises.

D. The AR's Appeal of the Internal Investigation Findings

DI 201 states:

When the investigation is closed, the advocate will discuss the determination of the investigation and the facility director's actions with the client and advise the client of the right to pursue the matter through the human rights review process, if the client is dissatisfied with the findings.¹³

In July 2001, pursuant to DI 201, R.L.'s Authorized Representative orally requested that the internal investigation findings addressing the bruising and sexual abuse allegations be appealed to the Local Human Rights Committee. On December 13, 2001, the same request was presented in writing. However, the issues were not presented to the LHRC until October 3, 2002, effectively abridging the AR's right to LHRC review within a reasonable time.

Based on the facts and DI 201, VOPA finds that SEVTC failed to present the Authorized Representative's appeal of the bruising and sexual abuse investigative findings to the Local Human Rights Committee within a reasonable time.

E. Pre-Employment Screening Failures

Virginia Code §37.1-20.3 states in pertinent part:

- A. As a condition of employment, the Department [DMHMRSAS] shall require any individual who (i) accepts a position of employment at a state facility as defined in §37.1-1 and was not employed by that state facility prior to July 1, 1996 . . . to submit to fingerprinting and to provide personal descriptive information to be forwarded along with the

¹³ Current Title 12 *Virginia Administrative Code* §35-115-50 also allows abused individuals or their Authorized Representative to seek LHRC review if either is dissatisfied with the Facility Director's actions.

applicant's fingerprints through the Central Criminal Records Exchange to the Federal Bureau of Investigation for the purpose of obtaining criminal history record information regarding such applicant.

For purposes of clause (i) above, the Department shall not hire for compensated employment persons who have (i) been convicted of . . . assault and bodily wounding as set out in Article 4 (§18.2-51 et seq.) of Chapter 4 of Title 18.2. . . .

Virginia Code §18.2-57 (part of Article 4 of Chapter 4 of Title 18.2) establishes assault and battery as a criminal offense.

Department of Human Resource Management Policies and Procedures Manual policy 2.10 states:

Agencies should check references with the current and at least one former supervisor of the applicant who is the final candidate for the position. The reference check should attempt to obtain information such as the following:

- Name
- Employment dates
- Position title
- Position duties
- Beginning and ending salaries
- Training Completed
- Performance (work experience, KSA's competencies)
- Whether the employee would rehire the applicant
- Verification of any required license, certification or degree.

. . .

By its own admission, SEVTC failed to obtain a national criminal records check for the employee that assaulted and battered R.L. and later shot him. SEVTC likewise failed to conduct required pre-employment screening of the same employee by completing meaningful and effective reference checks, and failed to make adequate inquiry of the second employee's statement that he had been convicted of assault and battery. Absent full compliance with its own pre-employment screening requirements, neither employee should have been hired. Had the employees not been hired, the abuse confirmed by VOPA's investigation would not have occurred.

Based on the foregoing, VOPA finds that:

1. SEVTC failed to implement statutory and policy requirements related to pre-employment screening of the employee who committed the shooting. Specifically, with regard to this employee:

- a. SEVTC failed to obtain a national criminal records check as required by *Virginia Code* §37.1-20.3.
 - b. SEVTC failed to conduct adequate reference checks and otherwise check prior employment records.
2. SEVTC failed to require the second employee to properly and adequately complete the required disclosure of prior criminal convictions, and failed to make adequate follow-up inquiry concerning the employee's statement that he was convicted of "A&B."

VIII. DMHMRSAS RESPONSE

On December 17, 2002, VOPA forwarded a draft of this report to DMHMRSAS Commissioner James S. Reinhard, M.D., for comment. On January 24, 2003, Dr. Reinhard responded.

The response acknowledges that the shootings were "serious incidents" that cause a "great deal of concern and pose special challenges to us all in our efforts to continually improve our performance." The response also agrees that the Authorized Representative's request for LHRC review of the internal investigation findings regarding the bruising and sexual abuse incidents was unnecessarily delayed and that "the Office of Human Rights has taken appropriate corrective personnel action to remedy the situation."

However, following these positive and constructive comments, the response unfortunately veers to a less positive course of conclusory denial and apparent disregard of the evidence. For example, the response states that "SEVTC did conduct pre-employment screening as required by DMHMRSAS Departmental Instruction 506 (HRM) 98, *Candidate, Volunteer, Service Provider Notification and Background Verifications*, and DHRM Policy 2.10[.]" and claims that required criminal background checks were done. The evidence belies these claims. Specifically, it is indisputable that a national criminal records check was not completed for "the employee that assaulted and battered R.L. and later shot him," as required by the *Code of Virginia* and by DI 506. It is further indisputable that the second employee admitted to a conviction for "A&B," but then failed to further clarify the meaning of "A&B," set forth the "statute or ordinance" violated and the "County, City and State" where the conviction occurred, all as expressly required by the DMHMRSAS application form, effectively precluding meaningful and documented follow-up to confirm whether the conviction precluded employment under Virginia law. DMHMRSAS' undocumented claim that the required supplemental information was orally and satisfactorily obtained by the Human Resources Director [the apparent procedure "at the time of (these) hire(s)"] unfortunately falls far short of meaningful and responsible implementation of the General Assembly's admonition that persons convicted of assault and battery not be hired at training centers.

Next, the response claims that each incident, including the bruising incident, was reported "in a timely manner" and "thoroughly, timely and independently investigated." This troubling claim apparently relies on the premise that staff inquiry can responsibly end based on a resident's

initial explanation for serious injury. The flaw in this position is apparent and should not serve as a basis for a broad and loose policy that allows and relies on individual and subjective staff evaluations in all circumstances.¹⁴

Next, the response seeks to diminish the indisputable and unacceptable delay in presenting the AR's appeal of the internal investigation findings to the LHRC by stating that "... the OHR staff involved has no knowledge of the written request for LHRC appeal cited by VOPA." This assertion is surprising and disappointing since the AR and VOPA discussed the content of the AR's written appeal with OHR staff, thereby confirming both delivery and receipt of the appeal by SEVTC's OHR staff.

Finally, the response complains that the report should not reference the current Human Rights Regulations because such an approach seeks to apply current human rights standards not in effect at the time of the bruising, sexual abuse, and shootings. However, a simple review of DI 201, which was promulgated and was in effect when each instance of abuse occurred, confirms that the standards in effect at the time of the incidents were virtually identical to those found in the current regulations. Moreover, with regard to D.S.'s right to appointment of an Authorized Representative, the denial of this right both precedes and post dates the effective date of the current regulatory guarantee. Finally on this point, notwithstanding DMHMRSAS' incorrect claim that VOPA seeks to retroactively apply standards not in effect when the abuse occurred, the new regulations are properly referenced for purposes of recommended, prospective corrective action.

IX. CONCLUSION AND RECOMMENDATIONS

R.L. was subjected to multiple instances of abuse by an SEVTC employee, including assault and battery, resulting in serious bruising, sexual abuse, and being shot with a pellet gun. D.S. was shot with the same pellet gun by the same employee. A series of SEVTC missteps, mistakes, and procedural violations contributed to occurrence of the abuse, including its failure to conduct required pre-employment screening, failure to adequately and thoroughly investigate the assault and battery, failure to immediately notify the Facility Director of suspected abuse and failure to provide required reports of R.L.'s injuries and potential abuse, including notice to his Authorized Representative. In addition, SEVTC and DMHMRSAS have, for years, disregarded D.S.'s right to have an Authorized Representative. Finally, either intentionally or by inaction, SEVTC prevented review of its internal investigation findings by the Local Human Rights Committee for fifteen months. Based on the facts, issues, and violations presented in this report, VOPA makes the following recommendations:

1. That DMHMRSAS assure that facility staff immediately report suspected abuse, neglect, or exploitation to the Facility Director, as required by current Title 12 *Virginia Administrative Code* §35-115-50.

¹⁴ R.L. had no history of self abuse or accidents resulting in serious bruising. Moreover, after the shooting, R.L. told SEVTC staff that the gunman was the person who beat him. However, notwithstanding this new and, to use DMHMRSAS' term, plausible explanation, SEVTC failed to reopen the bruising investigation, strongly indicating that the response simply offers contrivance to avoid accountability.

2. That DMHMRSAS assure that Facility Directors immediately notify a resident's Authorized Representative of receipt of a staff report of suspected abuse, neglect, or exploitation of a facility resident, as required by current Title 12 *Virginia Administrative Code* §35-115-50.
3. That DMHMRSAS direct that Facility Directors immediately designate an Authorized Representative to make decisions for all facility residents who lack the capacity to give informed consent concerning any and all aspects of services affecting the resident, as required by current Title 12 *Virginia Administrative Code* §35-115-70.
4. That DMHMRSAS assure that any request by an Authorized Representative for review by a Local Human Rights Committee of a facility's internal investigation findings or director's actions on such findings be immediately presented to such Local Human Rights Committee.
5. That DMHMRSAS assure that applicants for employment at one of its facilities submit to fingerprinting and provide required personal descriptive information, and that such fingerprints and information be forwarded through the Central Criminal Records Exchange to the Federal Bureau of Investigation for the purpose of obtaining criminal history record information regarding such applicant, as required by §37.1-20.3, *Code of Virginia* (1950 as amended).
6. That DMHMRSAS assure that thorough and proper reference checks be undertaken and documented for all final candidates for a position at SEVTC and other DMHMRSAS facilities, as required by Policy 2.10 of the Department of Human Resource Management Policies and Procedures Manual.

Dated: March 26, 2003

Respectfully submitted,

Virginia Office for Protection and Advocacy
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Richmond, VA 23219
(804) 225-2046

Gary L. Conover, Managing Attorney

Kristin B. Cooper, Staff Attorney

EXHIBIT 1



COMMONWEALTH of VIRGINIA

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

JAMES S. REINHARD, M.D.
COMMISSIONER

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January 24, 2003

Heidi L. Lawyer, Acting Director
Virginia Office for Protection and Advocacy
Ninth Street Office Building
202 North 9th Street, 9th floor
Richmond, Virginia 23219

Dear Ms. Lawyer:

Thank you for the opportunity to review the draft VOPA Investigation Report regarding the alleged abuse in December 2000 and January 2001 of R.L. and D.S., residents at Southeastern Virginia Training Center (SEVTC). I appreciate and value your agency as an extra set of "eyes and ears" in our efforts to continue providing quality services to persons with developmental disabilities. Serious incidents such as the two you investigated cause me a great deal of concern and pose special challenges to us all in our efforts to continually improve our performance. I would like to assure you that the Department has made a commitment of zero tolerance of abuse and neglect in the State facilities. Toward this end, we have maintained a free-standing Abuse/ Neglect Investigations Management Unit separate from the facilities to assure independent oversight and supervision of the investigations process.

Before discussing the substance of your draft report, I would like to clarify a possible significant misunderstanding on VOPA's part. The report continually refers to 12 VAC 35-115 et seq. of the *Virginia Administrative Code* as an applicable legal requirement. This citation, however, is to the *Rules and Regulations To Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation and Substance Abuse Services*, which was not in effect at the time of the incidents. (It did not go into effect until November 21, 2001.) As you know, these regulations provide greater protections than the former regulations, which were in effect at the time of both of the incidents you investigated. At the time of the incidents, the human rights regulations in effect were 12 VAC 35-110-10 et seq., entitled *The Rules and Regulations to Assure the Rights of Residents of Facilities Operated by the Department of*

Heidi L. Lawyer
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Mental Health, Mental Retardation and Substance Abuse Services. I hope that the references in the report to the current regulations are a clerical/typographical error. It would be otherwise misleading and inaccurate for VOPA to apply standards from regulations that did not exist at the time.

I am attaching a detailed response to the draft report, with comments reflecting the specific cases.

In closing, I want to point out that I requested information from your office on January 8th, 2003, that I believed was necessary for us to review in preparing our response, however my request was denied by Mr. Conover. While I can appreciate the need for confidentiality and appreciate your granting us a 7-day extension on the deadline for a response, I want to make it clear that our ability to respond completely to the draft Report was impacted by this denial.

I trust that you and your staff will give our response the consideration that it deserves. If you have any questions, please do not hesitate to contact me at 804-786-3921.

Sincerely,

A handwritten signature in black ink that reads "James Reinhard". The signature is fluid and cursive, with a long horizontal stroke at the end.

James S. Reinhard, M.D.

**DMHMRSAS Response to Draft Report dated January 2003 from
Virginia Office for Protection and Advocacy ("VOPA")**

Facility: Southeastern Virginia Training Center ("SEVTC")
Case Nos. 01-0063 (R.L.) and 01-0064 (D.S.)

The following is offered as clarification of the Report issued by VOPA regarding case numbers 01-0063 (R.L.) and 01-0064 (D.S.). To avoid staff identifiers, this response will reference the two staff persons involved as staff A and staff B.

DMHMRSAS Departmental Instruction 201 (RTS) 00, *Reporting and Investigating Abuse and Neglect of Clients*, requires all employees to report any incident or allegation that could constitute abuse or neglect to the Facility Director. In the cases at hand, all three incidents were reported and investigated in a timely manner. The Department continues to monitor and assure continued compliance with D.I. 201.

All three allegations were thoroughly, timely, and independently investigated and appropriate findings were made. These investigative findings were reviewed and approved by the DMHMRSAS Investigations Manager. It should also be noted that the LHRC determined that the investigations were conducted properly pursuant to the applicable regulations.

The Bruising Incident

SEVTC staff discovered bruising on R.L.'s upper arms on December 18, 2000. On that date, this resident was seen by a nurse who assessed the bruises and provided appropriate treatment. At that time, R.L. told the staff person and the nurse on duty that he "ran into the washer machine". Because the resident's explanation for the bruising was plausible, and there was no other evidence to indicate abuse/neglect, an investigation was not initiated at that time. At the time of the bruising, Virginia Code § 51.5-37 required state facilities to report critical incidents and deaths. A critical incident was defined as "serious bodily injury or loss of consciousness requiring medical treatment." R.L.'s bruising did not rise to the level of a critical incident and thus, a report was not made to VOPA.

It was not until December 24, 2000, that R.L. implicated SEVTC staff with respect to his bruises. On December 24, 2000, while on a home visit, R.L. told his family that staff person C (not staff A or B) caused the bruises. At that time an abuse investigation was immediately initiated in accordance with D.I. 201. When the pellet gun incident occurred (January 1, 2001), R.L. then told the Investigator and Chesapeake Police that the employee who had shot him with the pellet gun (staff A) had caused the bruises.

The internal investigation did not substantiate abuse, because of the inconsistent

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statements by R.L. and the lack of corroborative evidence. When questioned by the Investigator, R.L. gave the following responses:

Questions with Investigator:

- Q. How did you get the bruises on your arms?
- A. *I did it myself.*
- Q. R., tell me what happened to you while you were in the laundry room?
- A. *I fell against the washer and dryer.*
- Q. Was anyone in the laundry room when you injured yourself?
- A. *No, I was by myself.*
- Q. R., what did you tell your mother about the bruises on your arm?
- A. *I told her (staff C) pushed me against the washer.*
- Q. Did C. push you against the washer?
- A. *No, he pushed me up against the wall.*
- Q. He pushed you up against the wall?
- A. *No, he hit me on my elbow with a shoe.*

After a thorough investigation, a finding of abuse/neglect could not be substantiated by a preponderance of the evidence, the standard required by D.I. 201.

Pellet Gun Incident

The facts surrounding the pellet gun incident at SEVTC are not in dispute. Pursuant to D.I. 201, the alleged shooter (staff A) and other staff (staff B) who saw the pellet gun in staff A's possession on facility property were suspended pending the independent investigation. The matter was referred to the Virginia State Police, who referred the matter to the local Chesapeake Police Department and the Commonwealth Attorney's Office for investigation and prosecution. Following the internal investigation, SEVTC concluded that there was substantial evidence to indicate that abuse occurred. Both staff A and staff B were terminated from employment, pursuant to DMHMRSAS and DHRM policy.

Sexual Assault Allegation

On February 19, 2001, R.L. made an allegation to his mother that he was sexually assaulted by staff A. SEVTC staff were informed of the allegation the next day. Upon receiving the allegation on February 20, 2001, SEVTC reported it to the Chesapeake Police. R.L. was not able to say when the alleged assault occurred, so one would have to assume that the alleged assault occurred prior to staff A's termination in early January. Neither the facility internal investigation nor the Chesapeake Police investigation revealed any evidence of sexual abuse of R.L.. Unfortunately, there was an apparent delay after the alleged incident before the sexual abuse allegation was reported. This delay seriously impeded the ability to recover both physical and testimonial evidence that

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may have corroborated or negated such an allegation. Neither the internal investigation nor the police investigation could substantiate that a sexual assault occurred.

From the fact that there was one previous unsubstantiated allegation of abuse involving bruising and one allegation of abuse with a pellet gun that was substantiated involving the same staff person, it does not rationally follow that sexual abuse must then have also occurred by that person. There is no basis for drawing such a conclusion. The two previous incidents involved allegations of physical abuse, not sexual abuse and therefore, no reasonable inference can be drawn from the previously dissimilar acts.

As a point of further clarification, the incidents involved in this case and the mother's appeal of findings to the LHRC occurred when the former human rights regulations (12 VAC 35-110-10 et seq.), entitled *The Rules and Regulations to Assure the Rights of Residents of Facilities Operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services*, were in effect. The current regulations (12 VAC 35-115-10 et seq.), however, are cited throughout the VOPA report as the guiding regulations for this matter. The current regulations became effective on November 21, 2001. Because these incidents occurred prior to that date, the former regulations were applicable.

Human Rights Issues

Staff from the Office of Human Rights (OHR) was in frequent contact with R.L.'s authorized representative (AR) throughout the course of each investigation. These contacts involved discussions of the outcomes of the various investigations and of the AR's preference to pursue further action. However, the OHR staff involved has no knowledge of the written request for LHRC appeal cited by VOPA.

The SEVTC LHRC heard the appeal of the R.L. case on October 3, 2002 and issued their response on October 22, 2002. The Office of Human Rights (OHR) acknowledges a delay in the scheduling of the LHRC hearing. The timing of the hearing was beyond normal standards, and the Office of Human Rights has taken appropriate corrective personnel action to remedy the situation.

Regarding D.S., he does not have a family member willing or able to serve in an AR capacity. In accordance with regulations, repeated attempts have been made to find someone to serve as his AR, but they have been unsuccessful. D.S.'s treatment and habilitation program have been, and continue to be, judicially authorized pursuant to Virginia Code § 37.1-134.21. This statute provides for judicial authorization of treatment for residents and patients who do not have authorized representatives.

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Employment Pre-Screening Background Checks

SEVTC did conduct pre-employment screening as required by DMHMRSAS Departmental Instruction 506(HRM) 98, *Candidate, Volunteer, Service Provider Notification and Background Verifications*, and DHRM Policy 2.10. Consistent with Virginia Code § 37.1-20.3, SEVTC requested criminal background checks on both staff persons. The criminal background checks, which included FBI fingerprint searches, were consistent with regulatory and legal requirements. The FBI did not show a criminal record for either former employee, and results from the State Police revealed no state criminal record for either employee. Therefore, both former employees were eligible for employment under Virginia Code.

Since then, SEVTC has taken steps to improve documentation of the criminal background checks. The facility Disclosure Form was revised so that it now records initiation of the search and the results more clearly. This form is completed and signed by the facility Human Resource Director for each potential hire.

SEVTC also obtained references from past employers on both former employees. At that time, the Supervisor for the cottage (Cottage Supervisor) in which the vacancy existed conducted the reference checks. Employment references were obtained for the employee that allegedly shot the pellet gun (staff A) from his current supervisor as well as two former employers at the time of his application. The references for staff A indicated that he had had satisfactory performance.

SEVTC could only confirm one prior employer for the employee who saw the pellet gun in staff A's possession on facility property (staff B), and obtained a reference from that employer. The *Disclosure Statement* completed by staff B indicated that he checked "yes" to the question of whether he had been convicted of or was the subject of pending charges; he also wrote "A&B – Jan.00." At the time of hire, it was the practice of the SEVTC Human Resource Director to discuss disclosure statements with candidates whenever there was a questionable entry to clarify the information provided. Any discovered offenses meeting the criteria set forth in Virginia Code § 37.1-20.3, or raising questions about the candidate's suitability, would have been addressed immediately with the Facility Director. Therefore, it is concluded that the Human Resources Director was satisfied with the explanation provided by the employee. Since that time, the facility Office of Human Resource Management has conducted all reference checks for all prospective hires (part-time or full-time positions).

Summary

Investigation into these incidents were initiated in a timely manner and in compliance with regulations and policy. Criminal background checks were made according to section § 37.1-20.3 of the *Code of Virginia*. Notification to VOPA was made in compliance with the requirements of Virginia Code § 51.5-37.1. Staff A and staff B

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were terminated by SEVTC from employment. Efforts, as indicated, have been made to make improvements in processes relevant to the issues raised. For example, to enhance documentation of pre-employment screening, SEVTC has revised its Disclosure Form and has made reference checks the sole responsibility of its Office of Human Resources. In addition, the Office of Human Rights has taken corrective action to ensure timely LHRC hearings. The DMHMRSAS Abuse and Neglect Investigations unit provided training on the reporting and investigating of suspected abuse and neglect to facility Human Rights Advocates and Internal Investigators on October 17th and 18th, 2002. The Department also has revised its Departmental Instruction # 401, Risk Management, which became effective in December 2002. Departmental Instruction # 401 now contains specific protocols for investigating unexplained injuries.